

# SSI Milwaukee Medicaid Managed Care

## Highlights of Federal Requirements for State Managed Care Programs

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## Federal Requirements

- ◆ Federal Requirements, detailed in Medicaid Managed Care Rule, relate to four main areas of managed care:
  - ✓ Quality Assurance Requirements
  - ✓ Grievance Requirements
  - ✓ Scope of Service Requirements
  - ✓ Rate Setting Requirements



# Quality Assurance

## ◆ General Requirement:

- ✓ All managed care organizations must give priority to quality assurance and engage in activities and efforts that demonstrably improve their performance.



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# Quality Assurance

## ◆ Specific Requirements:

### ✓ Performance Improvement:

- MCO must conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable improvement in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.
- MCOs must conduct an annual performance assessment using standardized measures specified by the State.



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## Quality Assurance

- ✓ Corrective Action
  - MCOs must take timely action to correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
- ✓ State must arrange for annual external quality review of the managed care program.
- ✓ State must report measures of consumer satisfaction and clinical performance of MCOs.
- ✓ State must monitor MCOs' standards for utilization review and management (authorization of services).



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## Grievance Requirements

- ◆ Each managed care organization must have a system in place for enrollees that includes a grievance process and access to the State's fair hearing system.
- ◆ The State must act on each enrollee grievance within 90 days from the day the MCO received the grievance or as expeditiously as the enrollee's health requires.



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## Scope of Services

- ◆ States must cover at least the following services (covered by Fee-For-Service Medicaid):
  - ✓ Nursing Homes
  - ✓ Inpatient and outpatient hospital
  - ✓ Physicians
  - ✓ Laboratory and x-ray services
  - ✓ Home health services
  - ✓ Rural health clinics
  - ✓ Family planning services
  - ✓ Early and periodic screening, diagnostic and treatment services (known as HealthCheck in Wisconsin)
  - ✓ Nurse mid-wife and nurse practitioner services
  - ✓ Pregnancy-related services, including prenatal care coordination and postpartum care
  - ✓ Inpatient and outpatient mental health and substance abuse evaluation and treatment



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## Scope of Services

- ◆ States must cover at least the following services:
  - ✓ Ambulatory services, as defined in a state's plan, for individuals under the age of 18 and groups of individuals entitled to institutional services
  - ✓ Oral interpretation services
- ◆ State must ensure the MCO provides the following information to enrollees:
  - ✓ Procedures for obtaining care in emergencies
  - ✓ How to access benefits and transportation including prior authorization procedures
- ◆ Required Information to Enrollees:
  - ✓ Specific information about participating MCOs (e.g. network, grievances, disenrollment, etc.)
  - ✓ Written notice of any significant change in an MCO's network or procedures 30 days prior to the change



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## Scope of Services

- ◆ States must assure that MCOs meet the following requirements regarding access to services:
  - ✓ MCOs must monitor and maintain a provider network with written agreements that is sufficient to provide access to all services covered by the State/MCO contract.
  - ✓ Geographic location, number of providers, specialization of providers, and providers accepting new patients must match the needs of the population.
  - ✓ Hours of operation must be adequate for the populations served.
  - ✓ Female enrollees must have access to a women's health specialist.
  - ✓ MCO must have procedures to obtain second opinions, out-of-network referrals and care when necessary.
  - ✓ MCO must provide contracted services 24/7 when medically necessary.



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## Rate Setting Requirements

- ◆ Basic requirements:
  - ✓ All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.
  - ✓ The contract must specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.



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## Rate Setting Requirements

### ◆ Specific Requirements:

- ✓ Data must be derived from Medicaid population.
- ✓ Rate cells must be sensitive to age, gender and case mix.
- ✓ Rates must include appropriate adjustments for medical cost trends, administration, and incomplete data.



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